**Sid’s Pharmacy**

PART A

**Patient REQUEST TO ACCESS PHI FORM**

*Patient fills out*

|  |  |
| --- | --- |
| Name: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
| Date of Request: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
| Date of Birth: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Method of Request: | (circle one) Written / Verbal\* |
|  |  |
| Description of Protected Health Information Requested: | |
|  | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  | |

* + - 1. This request will terminate sixty (60) days after the date listed below or upon the occurrence of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, whichever occurs first.
      2. I understand that the Pharmacy may deny my request if it is permitted to do so by state and federal law.
      3. I agree that the Pharmacy may provide a summary of the information requested instead of copies of the actual records. I agree to pay the Pharmacy all reasonable fees incurred in preparing the summary and providing it to me.
      4. I request that the information is delivered to me in (circle one): printed copy / e-mail / other electronic format (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

|  |  |
| --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Patient (or Personal Representative\*) Signature  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Printed Name  If signed by Personal Representative, state relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date |

(\*) If the Patient requests protected health information verbally rather than in writing, the request will be documented in the Patient’s medical record.

ORIGINAL: In Patient Documents (in patient Profile WinRx)

COPY: To Patient (or Personal Representative)